Kansas
Department for Children and Families

Referral for Services
Parent Skill Building Programs

Case Number:				Event Number:			
Date of Referral:				DCF Office:			
TO:				FROM:			
				TELEPHONE #:			
ADDRESS: Street/P.O. Box				ADDRESS: Street/P.O. Box			
City		State		City		State	
ZIP				ZIP			

CHILD'S NAME	DATE OF BIRTH

LOCATION OF THE CHILD **(NOTE: please do not include information to locate the child on parent's copy if parents are unaware of the child's location.)**			
PARENT/ CARE GIVER'S NAME			
ADDRESS			
CITY		ZIP CODE	
TELEPHONE NUMBER			
PARENT/CAREGIVER'S NAME			
ADDRESS			
CITY		ZIP CODE	
TELEPHONE NUMBER			

Referral Reason: (Select a referral reason in the first column)	**Referral Reason: (Select the service(s) in the same row)**
☐ Child under the age of one	☐ Parent Skill Building program (i.e. Kansas Infant Toddler, Home Visitor, Parents as Teachers, etc.)

Distribution: An × in the box indicates persons receiving a copy of this notice.

☐ File	☐ Parents/Caregiver of child	☐ Contractor Providing Services (If Applicable)	☐ Other